SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Filing at a Glance

Company: Unimerica Insurance Company

Product Name: Group Dental	SERFF Tr Num: UHLC-126626236	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 45650
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: DCOBAMD.UIC.06.AR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Jayne Jackowski, Lynn Kaisershot	Disposition Date: 05/17/2010
	Date Submitted: 05/12/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: COB Amendment	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/17/2010	Explanation for Other Group Market Type:
	State Status Changed: 05/17/2010
Deemer Date:	Created By: Jayne Jackowski
Submitted By: Jayne Jackowski	Corresponding Filing Tracking Number:

Filing Description:

Amendment to revise the COB provision to comply with new state law and regulations.

Company and Contact

Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst	Jayne.Jackowski@eams.com
3100 AMS Blvd.	920-661-2234 [Phone]

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

8002325432 [Ext]

Green Bay, WI 54313

920-661-9861 [FAX]

Filing Company Information

Unimerica Insurance Company
PO Box 150450
Hartford, CT 0606115-0450
(860) 702-6017 ext. [Phone]

CoCode: 91529
Group Code: 707
Group Name:
FEIN Number: 52-1996029

State of Domicile: Wisconsin
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Insurance Company	$50.00	05/12/2010	36454064

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/17/2010	05/17/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/17/2010	05/17/2010	Jayne Jackowski	05/17/2010	05/17/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Cover Letter	Jayne Jackowski	05/12/2010	05/12/2010

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Disposition

Disposition Date: 05/17/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form *(revised)*	Amendment	Approved-Closed	Yes
Form	Amendment	Replaced	Yes

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/17/2010
Submitted Date	05/17/2010
Respond By Date	

Dear Jayne Jackowski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Amendment, DCOBAMD.UIC.06.AR (Form)

Comment:

Your filing indicates that the filing company is Unimerica Insurance Company, but the amendment is for UnitedHealthCare.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/17/2010
Submitted Date	05/17/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: The amendment is for Unimerica and the correct form is attached.

Related Objection 1

Applies To:

- Amendment, DCOBAMD.UIC.06.AR (Form)

Comment:

Your filing indicates that the filing company is Unimerica Insurance Company, but the amendment is for UnitedHealthCare.

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Amendment	DCOBAMD.UIC.06.AR		Certificate Amendment, Insert Page, Endorsement or Rider	Initial			DCOBAMD.UIC.06.AR.pdf
Previous Version							
Amendment	*DCOBAMD.UIC.06.AR*		*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*			DCOBAMD.SR.08.AR.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Jayne Jackowski, Lynn Kaisershot

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Amendment Letter

Submitted Date: 05/12/2010

Comments:

Adding cover letter to filing.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover Letter

Comment:

Amend Dental COB Filing letter-UIC.pdf

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Form Schedule

Lead Form Number: DCOBAMD.UIC.06.AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/17/2010	DCOBAMD.UIC.06.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment	Initial			DCOBAMD.UIC.06.AR.pdf

Coordination of Benefits Amendment

Unimerica Insurance Company

As described in this Amendment, the Policy is modified to replace the Coordination of Benefits provision.

1. The following provision replaces the Coordination of Benefits provision in the *Certificate of Coverage*:

[Section 7:] Coordination of Benefits

[Section 7.1] Coordination of Benefits Applicability

The Coordination of Benefits ("COB") provision applies when a person has health or dental care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

[Section 7.2] Definitions

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization ("HMO") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan .

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense .

D. Allowable expense is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense .

(2) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(3) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(4) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. An example of these types of plan provisions include preferred provider arrangements.

E. Closed panel plan is a Plan that provides dental care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

[Section 7.3] Order of Benefit Definition Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

B.

(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations include insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan .

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan . However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

• The Plan covering the Custodial parent;

• The Plan covering the spouse of the Custodial parent;

• The Plan covering the non-custodial parent; and then

• The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan . If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

[Section 7.4] Effect on The Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan . The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan , the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

[Section 7.5] Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give The Company any facts it needs to apply those rules and determine benefits payable.

[Section 7.6] Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

[Section 7.7] Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the

covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

This amendment is subject to applicable terms and conditions of the Policy. All other provisions of the Policy remain unchanged.

[Effective Date of this Amendment: _____]

UNIMERICA INSURANCE COMPANY

_____

(Name and Title)

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	05/17/2010
Bypass Reason:	Amendment consists of state mandated language.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/17/2010
Bypass Reason:	Amendment is to policy DPOL.UNI.06 approved 10/4/07.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	05/17/2010
Comments:			

Attachment:

Amend Dental COB Filing letter-UIC.pdf

Unimerica Insurance Company

MN010-W115 6300 Olson Memorial Highway
Golden Valley, MN 55427

May 12, 2010

Filing Sent Via SERFF

Arkansas Department of Insurance
1200 West Third Street
3rd and Cross
Little Rock, AR 72201-1904

Subject: Coordination of Benefits Amendment
DCOBAMD.06.AR
Group Dental

Filing For: Unimerica Insurance Company
NAIC Number: 91529
FEIN Number: 52-1996029

We respectfully submit this form for your formal approval. This is a new form and is not intended to replace any forms previously filed with the Department.

This amendment will be used to update previously approved certificate to comply with changes in your state's coordination of benefits laws. We request the right to build the amendatory language into the certificate or leave it in the amendment format, whichever we feel is most appropriate.

These materials represent final printed format. Once approved, the forms will be used to support the issuance of our portfolio of group dental products offered in your state.

If you have any questions or concerns, please contact me at 1-800-232-5432 extension 12234. My mailing address is United Healthcare Insurance Company, PO Box 19032, Green Bay, Wisconsin 54307-9032. My email address is Jayne_S_Jackowski@uhc.com.

Sincerely,

Jayne Jackowski, FLMI, AIRC
Compliance Analyst

SERFF Tracking Number:	*UHLC-126626236*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*45650*
Company Tracking Number:	*DCOBAMD.UIC.06.AR*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*COB Amendment/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/12/2010	Form	Amendment	05/17/2010	DCOBAMD.SR.08.AR.pdf (Superceded)

Coordination of Benefits Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to replace the Coordination of Benefits provision.

1. The following provision replaces the Coordination of Benefits provision in the *Certificate of Coverage*:

[Section 7:] Coordination of Benefits

[Section 7.1] Coordination of Benefits Applicability

The Coordination of Benefits ("COB") provision applies when a person has health or dental care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payment from all Plans does not exceed 100% of the total Allowable expense.

[Section 7.2] Definitions

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization ("HMO") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan .

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense .

(2) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(3) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(4) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. An example of these types of plan provisions include preferred provider arrangements.

E. Closed panel plan is a Plan that provides dental care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

[Section 7.3] Order of Benefit Definition Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

B.

(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations include insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan . However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan . If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

[Section 7.4] Effect on The Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan . The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan , the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

[Section 7.5] Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give The Company any facts it needs to apply those rules and determine benefits payable.

[Section 7.6] Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

[Section 7.7] Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the

covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

This amendment is subject to applicable terms and conditions of the Policy. All other provisions of the Policy remain unchanged.

[Effective Date of this Amendment: _____]

UNITEDHEALTHCARE INSURANCE COMPANY

_____

(Name and Title)